PRINTED: 07/14/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS395AGC 07/09/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1748 MINER WAY ST JOSEPH GROUP CARE 7 LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 7/9/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness. The census at the time of the survey was six. Six resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed and one non-admitted resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 105 449.200(1)(f) Personnel File - Background Check Y 105 SS=E NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by: Based on record review on 7/9/09, the facility failed to ensure 1 of 2 caregivers had 2 sets of

(f) Evidence of compliance with NRS 449.176 to

449.185, inclusive.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
NVS395AGC				B. WING		07/09/2009				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•				
ST JOSEPH GROUP CARE 7				1748 MINER WAY LAS VEGAS, NV 89104						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE			
Y 105	Continued From page	: 1		Y 105						
	fingerprints or proof of FBI background checks on file from 1/24/06 fingerprinting (Employee #1).									
	Severity: 2 Scope: 2									
Y 177 SS=C	449.209(4)(d) Health and Sanitation-Dirt, S=C Garbage, Refuse			Y 177						
	facility must be kept for	icable, the premises of ree from: dirt, garbage and other								
	Based on observation the exterior was kept	of met as evidenced by: a, the facility failed to en clean from refuse (Elev ns sitting in the back ya	nsure /en							
	Severity: 2 Scope:	3								
Y 223 SS=F	449.213(3) Laundry-L	inen - Equipment, Ven	ting	Y 223						
	be situated in an area area where food is sto The laundry must be a needs of the facility a manner. The laundry one washer and at lea equipment must be keeping and a situation of the situation	n a residential facility many which is separate from pred, prepared or serve adequate in size for the not maintained in a sanion room must contain at last one dryer. All the ept in good repair. All atted to outside the build	n an ed. e itary least							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		NIVO205 A CO		A. BUILDING B. WING	<u> </u>	07/0	0/0000	
NAME OF PR	ROVIDER OR SUPPLIER	NVS395AGC	STREET ADD	L RESS, CITY, STA	ATE, ZIP CODE	1 07/0	9/2009	
ST JOSEPH CROUP CAPE 7			l	MINER WAY VEGAS, NV 89104				
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Y 223	If a washer or dryer is residential facility, the a room or enclosure. This Regulation is no Based on observation	s located outside the e washer or dryer must	: failed	Y 223				
Y 253	manner (two clorox p amout of lint behind t found on the dryer). Severity: 1 Scop	lastic bottles and large he dryer and no dryer h	•	Y 253				
SS=C	NAC 449.217 4. The administrator	of a residential facility s it least a 2-day supply o st a 1-week supply of						
	Based on observation	ot met as evidenced by n on 7/9/09, the facility at least 2 day supply of ply of canned food.	failed					
Y 566 SS=F	Severity: 1 Scope 449.267(2)(a)-(c) Mo Residents			Y 566				

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administration of the medication shall: (1) Comply with the order.

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ST JOSEPH GROUP CARE 7		LAS VEGAS, NV 89104					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
Y 878	Continued From page 4		878				
	This Regulation is not met as evidenced by: Based on record review and interview on 7/9 the facility failed to ensure 3 of 6 residents received medications as prescribed (Resider #4 and #6). Severity: 2 Scope: 3	9/09,					
Y 883 SS=F			883				
	NAC 449.2742 7. If a resident refuses, or otherwise misses, administration of medication, a physician munotified within 12 hours after the dose is refuor missed.	ıst be					
	This Regulation is not met as evidenced by: Based on interview and record review, the fa failed to ensure the physician was notified for missed medications for 3 of 6 residents ((Resident ##3, #4 and #6).	acility					
	Severity: 2 Scope: 3						
Y 885 SS=D	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinuithe expiration date of the medication of a resident.	ued,	885				

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(2) The date of its delivery;

delivery:

(3) The name of the person who accepted the

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This Regulation is not met as evidenced by: Based on record review on 7/9/09, the facility

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		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-			
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Y 898	Continued From page	e 7		Y 898					
	failed to ensure the medication administration record (MAR) was accurate for 6 of 6 residents (Resident #1, #2, #3, #4, #5 and #6).								
	Severity: 1 Scope: 3								
Y 936 SS=F				Y 936					
	NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.								
	Based on record revie failed to ensure 2 of 6	ot met as evidenced by ew on 7/9/09, the facilit residents complied wi ding tuberculosis (Resi	y th						
	This was a repeat def State Licensure surve	ficiency from the 9/9/08 ey.	3						
	Severity: 2 Scope	e: 3							
Y 944 SS=C	449.2749(2) Resident	t File / Discharge		Y 944					
	NAC 449.2749 2. The document requ	uired pursuant to parag	ıraph						

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